Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division of Health Professions Licensure

Board of Registration in Pharmacy
239 Causeway Street, 5th Floor, Boston, MA 02114
617-727-9953 (office) 617-727-2366 (fax)
www.mass.gov/reg/boards/ph

MITT ROMNEY
GOVERNOR

KERRY HEALEY
LIEUTENANT GOVERNOR

RONALD PRESTON
SECRETARY

CHRISTINE C. FERGUSON
COMMISSIONER

APPLICATION FOR REGISTRATION TO MANAGE AND OPERATE A NEW COMMUNITY PHARMACY

In order to register with the Board of Registration in Pharmacy to manage and operate a pharmacy or pharmacy department in the Commonwealth of Massachusetts, the pharmacist Manager of Record shall submit a completed application to the Board. All applications must contain the following:

1. An Application for a New Store permit (enclosed and or available on website), completed and signed by the pharmacist Manager of Record.
2. A Store Hours form (enclosed and or available on website), completed to reflect the hours during which the pharmacy or pharmacy department is to remain open.
3. An application for a Massachusetts Controlled Substance Registration (enclosed and or available on website).
4. An application, if applicable, for a Certificate of Fitness (enclosed / and or available on website).
5. An official blueprint of the facility, drawn to scale, with the proposed pharmacy or pharmacy department outlined in RED. **It should be noted that the prescription area shall not be less than 300 square feet**; and must be so located that it is not a passageway to other parts of the pharmacy.
6. A check or money order made payable, in the proper amount, to the Commonwealth of Massachusetts.

When a pharmacist applies for a registration to manage and operate a pharmacy or pharmacy department on behalf of a corporation, the following additional information is required.

1. A copy of the corporation's Articles of Organization, signed and sealed by the Massachusetts Secretary of State, if the corporation is incorporated in the Commonwealth.
2. A copy of the corporation's Foreign Corporation Certificate, signed and sealed by the Secretary of State (M.G.L.c.181, s.4), if the corporation is incorporated in another state.
3. A statement of the name and address of each officer and director of the corporation and position held.
4. The D.B.A. name of the corporation.
5. The total amount and type of stock issued to each stockholder and names and addresses of said stockholders, if the corporation is not publicly owned.

Please be advised that no application for registration to manage and operate a pharmacy or pharmacy department shall be acted upon by the Board less than 15 days after receipt by the Board of the fully and properly completed application. Before acting on an application, the board may require additional information and request that the applicant personally appear before the Board. The purpose of any meeting scheduled with the Board is to determine whether the issuance of a registration would be in the best interest of the public's health, welfare and safety, as set forth in M.G.L.c.112, s 39.

In addition, the Board requires an **inspection** of the pharmacy or pharmacy department before any approval of an application is granted.

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APPLICATION FOR A NEW STORE

BOARD USE ONLY
Board_____
License #_____
Type_____
Cash #_____
Cash Date_____

I hereby apply for a permit to operate a store for the transaction of retail drug business in accordance with the provisions of Chapter 112, General Laws.

$351.00 licensure / application fee. Make check or money order for **$351.00** payable to the Commonwealth of Massachusetts. **This fee is non-refundable.**

1. Legal Name of Business._____

BOARD USE ONLY
Status Code_____ **Issue Date**_____ **Lic. Exp Date** _____

2. Full Business Address (Street Address, City, State and Zip)._____
   _____
3. Area Code and Telephone Number._____
4. All trade or business names ("D.B.A." names) used by same Corporation or by License._____
   _____
   _____
5. Type of ownership or operation (i.e., sole proprietorship, partnership, corporation)._____
   _____
   If corporation, please submit articles of corporation.
6. Names(s) and Social Security Number(s) of the owner(s) and/or operator(s) of the licensee. *Please indicate type of ownership - Partnerships: the name of each partner and name address of partnership; Corporations: the name and title of each corporate officer and director, the corporate names, name and address of parent company, if any, and the State of incorporation; Sole Proprietorship: the name of the sole proprietor and the address of the business entity*._____
   _____
   _____

7. Name of registered pharmacist charged with the management of the pharmacy._____

8. Registration number of above manager._____

9. Name(s) and registration number(s) of staff pharmacist(s) employed at pharmacy._____

10. Have any of the applicant(s) and/or managers-in-charge had: 1) any convictions related to the distribution of drugs (including samples); 2) any felony convictions; 3) any suspension(s) or revocation(s) or other sanction(s) by federal, state or local governmental agency of any license or registration currently or previously held by the applicant or license for the manufacture, distribution, or dispensing of any drugs, including controlled substances? Have any applications for licensure been denied by any federal or state agency including any state board of pharmacy? List and explain. Attach additional sheets if necessary.

11. The applicant/licensee must notify the Board in writing of any changes in ownership or management within thirty (30) days of such change(s).

12. Social Security Number (**Mandatory**)._____
Pursuant to G.L. c. 62C, s. 47A, the Division of Registration is required to obtain your social security number and forward it to the Department of Revenue. The Department of Revenue will use your social security number to ascertain whether you are in compliance with the tax laws of the Commonwealth.

13. List any licenses/certifications you hold in the United States or any country or foreign jurisdiction and the state/ jurisdiction from which the license/certification was originally issued. Please attach a certificate of standing from each state or jurisdiction in which you are licensed/certified, indicating the status of your license and any relevant disciplinary information._____

14. Has any disciplinary action been taken against you by a licensing/certification board located in the United States or any country or foreign jurisdiction? Yes: □ No: □
If yes, please state the details (use a separate sheet if necessary)._____

15. Are you the subject of pending disciplinary actions by a licensing/certification board located in the United States or any country or foreign jurisdiction? Yes: □ No: □
If yes, please state the details (use a separate sheet if necessary)._____

16. Have you ever voluntarily surrendered or resigned a professional license to a licensing/certification board in the United States or any country or foreign jurisdiction? Yes: □ No: □
If yes, please state the details (use a separate sheet if necessary)._____

17. Have you ever applied for and been denied a professional license in the United States or any country or foreign jurisdiction? Yes: □ No: □
If yes, please state the details (use a separate sheet if necessary)._____

18. Pursuant to Board Regulations at 247CMR δ 6.01(3), **The Board shall not register nor permit ownership of a pharmacy or pharmacy department by a practitioner with prescriptive privileges**. By signing this application the applicant certifies that none of the owners, directors or officers have prescriptive privileges.

Affidavit (must be completed and notarized)

Pursuant to M.G.L. c. 62C, s. 49A, I certify under the penalties of perjury that I, to the best of my knowledge and belief, have filed all state tax returns and paid all state taxes required under law.

The applicant certifies that each person employed in any prescription drug distribution activity has the education, training, and experience, or any combination thereof, sufficient for that person to perform the assigned functions in such a manner as to provide assurance that the drug product quality, safety, and security will at all times be maintained as required by law.

I hereby state that I am the person authorized to sign this application for all licensure; that all statements are true and correct in all respects and are made under the penalties of perjury.

_____
Signature of pharmacist who is to manage the pharmacy or pharmacy department

_____
Date

_____
Social Security Number of managing pharmacist

Sworn and subscribed before me this_____day of _____

My commission expires_____ . _____
Notary Public

To be completed by the Board: Check $_____ Date_____ Number_____